TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ronald D. Linderman, D.C.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-18-0188-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 22, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DOS: 2-9-17 … The questions/determinations asked of me by the enclosed DWC-32 were addressed in accordance to labor code 408.004, 408.0041, 408.151, and division rules and were billed accordingly.

The appropriate billing charges by me were submitted and I was not paid in accordance with the DWC rules."

Amount in Dispute: $800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This dispute involves date of service on bill 2/21/2017 is inconsistent with date of service 2/9/17 on the DWC69 and the narrative report. Because of this inconsistency Texas Mutual declined to issue payment."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 21, 2017	Designated Doctor Examination	$800.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment

- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code description/instructions.

Issues

Is Texas Mutual Insurance Company's reason for denial of payment supported?

Findings

Ronald D. Linderman, D.C. is seeking reimbursement for a designated doctor examination performed on February 21, 2017. Texas Mutual Insurance Company (Texas Mutual) denied the disputed services with claim adjustment reason code 225 – "THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION."

The submitted CMS-1500 indicates a date of service of February 21, 2017. The submitted Report of Medical Evaluation (DWC069) and narrative indicate a date of service of February 9, 2017. Texas Mutual's denial reason is supported. No reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	October 30, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.